Rhode Island KIDS COUNT

Issue Brief

ACCESS TO DENTAL CARE FOR CHILDREN IN RHODE ISLAND

Dental caries (tooth decay) is the most common preventable chronic childhood disease. The recently released U.S. Surgeon General's report on oral health highlights the problem of dental disease as a silent epidemic in America. Dental disease restricts activities in school, work, and home and often significantly diminishes the quality of life for many children and adults, especially those who are low-income or uninsured. Among U.S. parents reporting children's unmet health care needs, 57% report unmet dental needs.

THE EFFECTS OF INADEQUATE DENTAL CARE

Pain from untreated dental disease can lead to eating, sleeping, speaking, and learning problems in children and adolescents. It can affect a child's social interactions, school achievement, general health, and quality of life.

- Chronic poor oral health is associated with failure-to-thrive in toddlers and poor nutrition and dysfunctional speech in children.
- In school-age children and adolescents, chronic dental problems can lead to reduced school performance, poor self-image, lack of concentration, and absenteeism.
- A key indicator of dental health is the number of restricted activity days, such as missed days of school or work due to dental problems. More than 51 million school hours are lost each year due to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families.
- Over 50% of five to nine-year-olds and 78% of 17-year-olds have at least one cavity or filling. If left untreated, dental caries can cause serious pain for children and can lead to high-cost emergency hospital care.
- The National Institute of Dental Research reports that 80% of tooth decay occurs in only 25% percent of children and adolescents - primarily children from low-income families.

JANUARY 2001
UPDATED MAY 2002

Children at Greatest Risk for Unmet Dental Needs

Low-Income Children

- Children from low-income families are at highest risk for tooth decay. For every decayed tooth in groups of children over 300% of the federal poverty level, there are five decayed teeth in groups of children under 100% of the federal poverty level.

- A recent national study found that nearly twice as many low-income children as higher-income children reported unmet dental needs; 29% of low-income children versus 14% of higher-income children have had no dental visits.

- One in three preschoolers who have family incomes below $10,000 have untreated tooth decay compared with one in ten preschoolers who have a family income above $35,000. Head Start reports that nearly 30% of enrolled children identified to have tooth decay do not have access to dental care.

Minority and Immigrant Children

- Health surveys consistently show that minority children are more likely to have unmet dental need than other children. Children of color are more than one-and-a-half times more likely to have a dental visit because of pain than white children.

- In a recent national study, 50% of foreign-born children had no dental visits compared with 28% of U.S.-born children.

Children with Special Health Care Needs

- Children with fair or poor health have greater levels of unmet dental needs and lower probability of having dental visits than children in better health.

- Access to comprehensive oral health care is critical for children with special health care needs. Medications, therapies, special diets, and difficulty in cleaning teeth complicate dental care and treatment. Children with developmental disabilities often have enamel irregularities, gum infections, delays in tooth eruption, and oral infections.

- Low-income families and families who have children with serious health problems often must balance dental care with other competing health care needs. Parents may not view dental care as a priority.

- Dentists may be reluctant to treat children with special needs whose care can be complex and time consuming. In Rhode Island, the Samuels Dental Center provides comprehensive dental care services for children with special health care needs.

FAMILIES WITH ACCESS BARRIERS

- Families who are entitled to dental services may have difficulty making and keeping appointments due to lack of access to transportation, language barriers, and child care problems.
- Parents may not be aware of the importance of regular dental care and how to prevent oral health problems. Dental professionals report that some children who are served by school-based dental programs do not regularly brush their teeth and have never had a dental exam.
- Children of parents with low educational attainment have fewer dental visits and are less likely to receive regular care.

YOUNG CHILDREN

- Many parents are not aware that regular, routine dental visits are important for children beginning at age one.
- Early childhood caries, also known as baby bottle tooth decay, is rampant decay in the primary teeth of infants and toddlers. It is caused by frequent and prolonged exposure to the teeth of carbohydrates, particularly sugar in juice, milk, or infant formula. This exposure is the result of putting a child to bed with a bottle containing sugary liquid, or allowing a child to drink from a bottle throughout the day.
- Nationally, 3% to 10% of young children have early childhood caries. This rate is significantly higher among children from low-income families; up to 20% of children from low-income families have this condition.
- Treatment of early childhood caries often requires extensive restorative work, stainless steel crowns, or tooth extraction, with general anesthesia in many cases. Prevention of early childhood caries requires parent education regarding healthy child nutrition and oral hygiene, a first dental visit by 12 months of age, and ongoing preventive therapy and dental treatment.
- According to the 1996 Rhode Island Health Interview Survey, 20% of parents reported that their child sleeps with a baby bottle once in a while, 16% reported that their child does so sometimes, and 14% reported that their child does so most of the time.

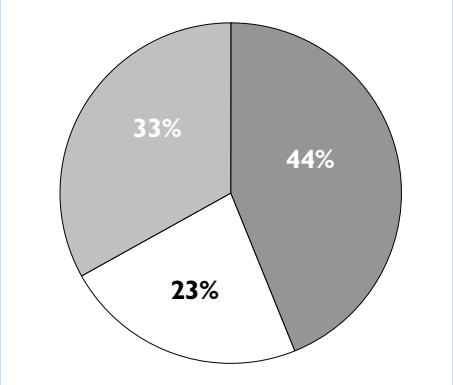
PREVENTION AND TREATMENT

Parent Education. Educating parents about the importance of routine dental care beginning at age 12 months and good nutritional and eating habits can help to prevent early childhood caries and later dental problems. Education must be tailored to the parents' education level, language, culture, and their understanding of how to access dental care.

Fluoridated Water. Fluoride added to a community's water supply helps prevent tooth decay. Nineteen percent of Rhode Island's population, mostly in rural areas, do not have access to fluoridated water.

Dental Sealants. Eighty percent of dental decay in children occurs on the chewing surfaces of teeth. Dental sealants, thin plastic coatings that are applied to the chewing surfaces of back teeth, can significantly reduce the risk of cavities. The U.S. Healthy People 2000 goal is for 50% of 3rd grade children to have dental sealants. Nationally, 23% of children have at least one sealed tooth. The rate of dental sealant placement is significantly lower for minority children than white children. Analysis of claims for RIte Care enrollees shows that for children under age 14, 28% had dental sealants.

DENTAL INSURANCE COVERAGE, CHILDREN* AGES 5-19, RHODE ISLAND, 1996



COMMERCIAL INSURANCE: 44%
PUBLIC INSURANCE: 23%
NO COVERAGE: 33%

*Source: 1996 Rhode Island Health Interview Survey; *Includes children in families with incomes less than 300% of the federal poverty level.*

Children in families without dental insurance are three times more likely to have untreated dental disease than children with dental insurance.

Children eligible for Medicaid experience twice the ratio of untreated dental disease as more affluent children.

Of all Rhode Island children under age 21 enrolled in public insurance programs (RIte Care and Medicaid), one-in-three accessed dental prevention treatment services in state fiscal year 2000.

AVAILABILITY OF DENTAL SERVICES FOR CHILDREN RECEIVING MEDICAL ASSISTANCE

In Rhode Island as of December 31, 2000, there were 69,254 children under age 19 enrolled in RIte Care, Rhode Island's Medicaid Managed Care program. An additional 11,268 children were enrolled in Medicaid fee-for-service (primarily children in the care of DCYF, children receiving SSI, and children with disabilities who do not qualify for SSI).

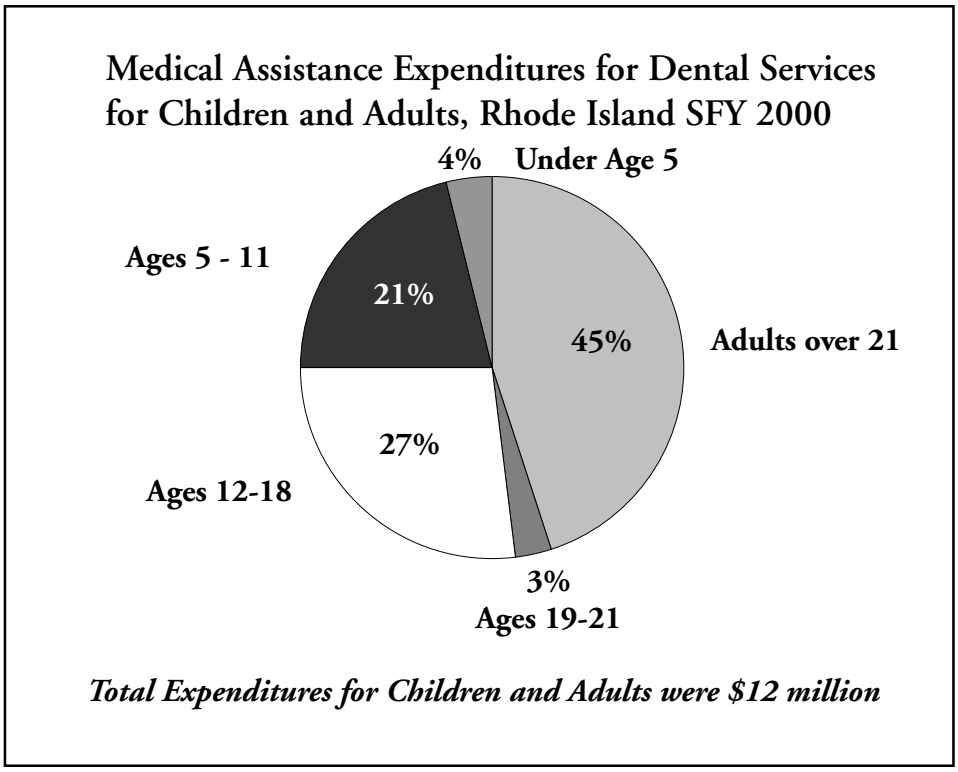
All children enrolled in RIte Care and Medicaid fee-for-service are entitled to comprehensive dental prevention and treatment services. The federal Medicaid program mandates that states provide comprehensive dental services to eligible children up to age 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Dental services provided to RIte Care enrollees are paid for by Medicaid (with a federal-state funding match) on a fee-for-service basis. Through this system, Medicaid directly pays dentists who choose to participate in the program for the dental services delivered.

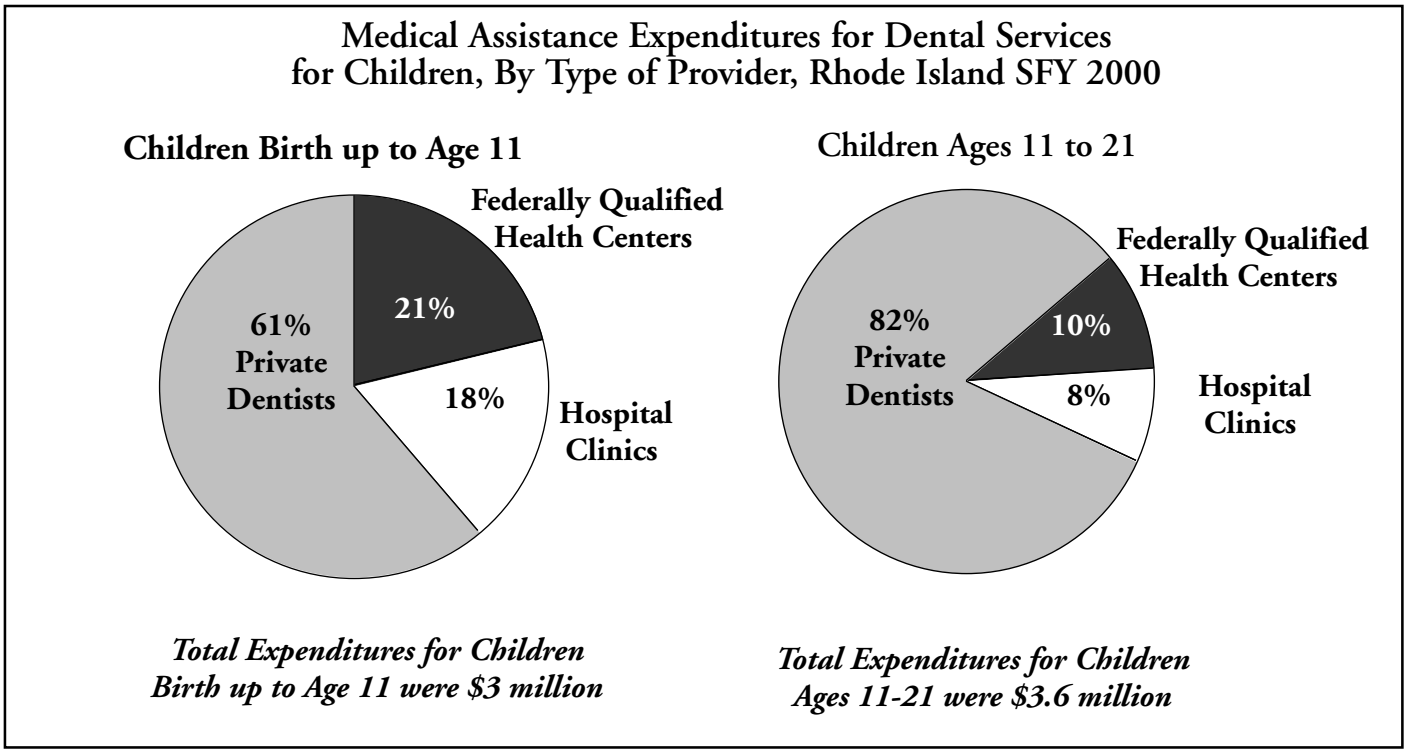
The recent federal expansion of children's public health insurance under the State Children's Health Insurance Program (CHIP) has enabled Rhode Island to increase the number of children and families served through RIte Care. Rhode Island is required to provide the Medicaid benefit package, which includes comprehensive dental services, to children insured through the CHIP funds for Medicaid expansion.

The RIte Care plans refer RIte Care clients for preventive dental care and dental treatment services. States are required to recruit dentists to provide dental services under EPSDT, to locate eligible families and inform them about EPSDT services, and assure that providers perform the required services.

CURRENT RESOURCE ALLOCATION FOR DENTAL SERVICES FOR CHILDREN AND ADULTS RECEIVING MEDICAL ASSISTANCE

In state FY 2000, the Rhode Island Department of Human Services spent $12 million of state and federal funds on dental services for children and adults enrolled in Medical Assistance programs (RIte Care and Medicaid fee-for-service). Of this, 55% was spent on dental services for children and adolescents up to age 21. Only one-third of children eligible for dental services through Medicaid have had a dental prevention or treatment visit in 2000. Children up to age 11 are more likely to receive care at community health centers and hospital-based clinics than children ages 11 to 21.





SHORTAGE OF DENTAL PROVIDERS

Rhode Island has five federally-designated dental health professional shortage areas because of the low number of dentists for the total population of adults and children.

Clients with public insurance for dental care have greater access problems than the general population.

Participation rates of dentists who serve low-income children enrolled in Medicaid are very low. Statewide, there are 113 RIte Care enrollees for each Medicaid dental provider. In the five core cities there are more than 220 RIte Care enrollees per Medicaid dental provider.

Access to services has been reduced further in Providence with the closing of two dental clinics at the Providence Ambulatory Health Center in 1999.

A 1997 survey among Rhode Island dentists who do not accept Medicaid clients indicates that low reimbursement rates, excessive number of no-shows, excessive paperwork, and lengthy payment processing times are the most common reasons for not serving as a Medicaid dental provider.

DENTAL SERVICES FOR RHODE ISLAND CHILDREN

COMMUNITY HEALTH CENTERS

Of the thirteen Community Health Centers throughout the state, five offer dental services to children. These include: Thundermist Health Associates in Woonsocket; New Visions of Newport County; Health Center of South County in Wakefield; Wood River Health Services in Hope Valley; and Blackstone Valley Health Center in Pawtucket. Northwest Health Center is planning to open a dental clinic in 2001. These clinics serve children enrolled in Medicaid. The clinics also offer a sliding scale fee for children who are uninsured. The average wait for an appointment is four to six weeks.

PRIVATE DENTISTS

In Rhode Island there are 512 private practice dentists statewide. A 1997 survey of dentists in Rhode Island found that 78% served clients with public insurance through Medicaid. While many dental providers in the state do not accept Medical Assistance for payment and/or limit the number of Medical Assistance clients they will treat, private dental practices continue to be the largest provider of dental services to the Medicaid population. In state fiscal year 2000, private dental practices accounted for 73% of all Medicaid dental expenditures for children up to age 21.

HOSPITAL-BASED DENTAL SERVICES

The Samuels Dental Center at Rhode Island Hospital provides pediatric dental services for children and adults as well as special services for children with disabilities. Samuels Dental Center at Rhode Island Hospital provides pediatric dental services to children with special needs. The clinic is staffed by two full-time dentists, including one pediatric dentist and three part-time dental hygienists. About 40% of the patients served at Samuels are children from the community, 40% are children and adults with special needs, and 20% are adults seeking emergency treatment. Due to recent closings of other clinics offering dental services, Samuels has a waiting list of well over 450; once off the waiting list, it can take one to two months for an appointment with a dentist and three months for an appointment with a dental hygienist.

St. Joseph Hospital Pediatric Dental Center opened in 1995 in response to the need for dental care among patients regularly seen at the Primary Care Clinic. The Dental Center employs two full-time dentists, one of whom is a pediatric dentist, and two full-time and one part-time dental hygienists. The Center offers a full range of preventive and restorative services. The hospital serves uninsured patients, or if a patient qualifies, offers a sliding scale fee. The Dental Center is the only clinic in Providence that is accepting new patients. The wait for an appointment is two to three months for non-emergency care.

SCHOOL-BASED DENTAL SERVICES

Providence Smiles, a program of St. Joseph Hospital, provides dental disease prevention, treatment and education to elementary school children and their families in ten Providence Schools. The program sends dentist and dental hygienist teams into schools to examine and clean children's teeth, fill decayed teeth, administer fluoride treatments, and apply dental sealants. After a preliminary examination, children must return a parental consent form before further treatment is administered. Children with more serious dental problems who lack a family dentist are referred to St. Joseph Hospital Pediatric Dental Center. Providence Smiles also identifies children without health insurance and assists eligible parents with enrolling in RIte Care, Rhode Island's Medicaid managed care program.

School-Based Health Centers also provide on-site dental care for children. There is a school-based health center at Central Falls High School which provides dental care through Blackstone Valley Community Health Center. In Pawtucket there are plans for adding dental services - replicating the Providence Smiles Program - at the school-based health center at Slater Junior High School. School districts can receive Medicaid reimbursements for dental screenings, dental sealants, and other school-based dental services for children enrolled in RIte Care or Medicaid.

SCHOOL-BASED DENTAL SCREENINGS

Each school in Rhode Island is required to conduct a dental screening of all children entering a Rhode Island school for the first time, K-5 students annually, and at least once in 7th to 10th grades. Schools are required to notify the parent when the dental screening indicates that a problem exists, to document the results of the dental screening in the child's school health record, and to maintain a referral list.

Parents receive a card from their child's school on which they must indicate whether their child has received a dental screening or exam. If a parent indicates that a child has not received a dental exam, the school contracts with a dentist to perform a dental screening. School districts can receive Medicaid reimbursements for dental screenings, dental sealant programs, and other school-based dental services.

RHODE ISLAND RESOURCES

Senate Commission on Access to Oral Health, *Senator Elizabeth Roberts, Chairperson,* 222-6655.

Rhode Island Dental Association, *Dr. Nicholas D. Barone, Chairperson, Valerie Donnally, Executive Director*, 732-6833.

Rhode Island Dental Hygienists Association, *Susan Perlini, President,* 333-0690.

Rhode Island Health Center Association, *Kerrie Jones Clark, Executive Director,* 274-1771.

The Poverty Institute at RI College School of Social Work, *Linda Katz, Policy Director,* 456-4634.

Rhode Island Dentistry for the Handicapped, *Dr. Clark Sammartino, President*, 728-9448.

Providence Smiles, *Christine Vallee, Dr. Daniel Kane, Co-Directors,* 456-4054.

Samuels Dental Center, *Dr. Shirley A. Spater, Director*, 444-5284.

Ocean State Action Fund, *Kathryn Hopkins, Policy Director*, 463-5368.

RI Department of Human Services, *John Young, Medicaid Director*, 462-3575.

RI Department of Health, *Dr. Robin Lawrence, Maureen Ross*, 222-7620.

RI Department of Elementary and Secondary Education, *Jacqueline Ascrizzi, 222-4600.*

Delta Dental of Rhode Island, *Kathryn Shanley, Vice President for External Affairs*, 752-6100.

Blue Cross Dental, *Dr. Rodney P. Thomas, Dental Director*, 831-7300.

Neighborhood Health Plan of RI, *Christopher F. Koller, Chief Executive Officer,* 459-6000.

STRATEGIES TO IMPROVE ACCESS TO DENTAL SERVICES FOR LOW-INCOME CHILDREN IN RHODE ISLAND

Increase reimbursement rates to dental providers caring for children receiving Medical Assistance (RIte Care and Medicaid fee-for-service).

A higher rate of reimbursement for dental prevention and treatment services is critical to the long-term sustainability of hospital-based dental clinics, which are a core component of the dental service infrastructure in Providence. The higher reimbursement rates are also critical to private dentists that serve large numbers of children enrolled in RIte Care, Medicaid, or SSI. Rhode Island reimbursement rates currently average 45% of the usual, customary, and reasonable (UCR) fee levels for the most common dental problems. National research indicates that the average cost of operating a dental practice (overhead) exceeds 60% of total revenues. Increasing the reimbursement rates to Medicaid dental providers would help ensure that dental providers could cost-effectively serve Medicaid clients.

Explore the potential for a dental benefits manager as a strategy to reduce barriers to care and to increase accountability for providing the comprehensive dental prevention and treatment services required under federal Medicaid law.

In the Fall of 1998, the Department of Human Services established a Dental Advisory Committee to develop recommendations for improving access to dental services for individuals covered by Medicaid, including RIte Care. The Committee agreed in June 1999 to recommend that DHS develop purchasing specifications for a Dental Benefit Manager to manage and administer the dental program. The Committee recommended that the Dental Benefit Manager Program be offered as an option to the fee-for-service dental system for all program enrollees, with implementation on an incremental basis beginning with all children. The Dental Benefit Manager program (RIte Smiles) would provide a number of services, including establishing and maintaining geographically accessible provider networks comprised of primary and specialty dentists in adequate numbers to meet accessibility standards.

Maintain and strengthen the dental services infrastructure at the community health centers across the state.

The 14 community health centers in Rhode Island are an important resource for health and dental care for the most vulnerable children and families in the state. Sufficient resources are needed for capital improvements to existing dental clinics, additional clinics in underserved communities, recruitment of qualified dentists, services for the uninsured, and interpreters and transportation to ensure access by hard-to-reach populations. The federal government requires that federally-qualified health centers receive cost-based

reimbursements for dental services that are higher than the current reimbursement rates for hospital-based clinics and private dentists. However, these centers have the ongoing unfunded obligation of caring for uninsured adults who need dental care.

Sustain Providence Smiles - a comprehensive school-based dental program in Providence - and replicate the program in each of the other core cities: Pawtucket, Newport, Woonsocket, and Central Falls.

Providence Smiles, a pilot school-based dental sealant program, was launched in 1997 with start-up funds from Health and Education Leadership for Providence, the Rhode Island Foundation, and the Robert Wood Johnson Foundation. Medicaid is a major funding partner in this successful program which provides dental examinations, cleaning and fluoride treatment, sealants, simple restorations, referral for more extensive treatment, community outreach, and education. This program is a cost-effective mechanism for providing Medicaid-eligible children in low-income communities with dental prevention and treatment services. The program is currently being replicated in Pawtucket. Sustaining Providence Smiles through a long-term financing strategy and replication in the five core cities critical to improving access to dental care among children in Rhode Island's urban communities. Replication of the Smiles program should include attention to utilizing Medicaid reimbursements to finance school-based dental services and developing effective linkages between schools and community-based dental providers (private dentists, hospital dental clinics, and community health center dental clinics) in order to ensure that children receive needed dental treatment services.

Use the school-based dental screenings - required as part of the state school health regulations - to more effectively connect children with needed dental services.

The dental screening program in Rhode Island schools can be an important resource to ensure that all children have access to dental health services and that schools are active partners in this process. The effectiveness of school-based screening programs can be improved by developing data systems that track screening results, document referrals and receipt of necessary treatment, and actively connect families to a dental care provider when needed. Schools are important partners in documenting gaps in the dental care system in communities across the state. Partnerships between schools and dental providers can ensure that children in need of emergency treatment receive dental care promptly. School districts can receive Medicaid reimbursements for dental screenings, dental sealant programs, and other school-based dental prevention and treatment services.

Develop new revenue sources to finance dental care services for low-income children in Rhode Island.

In order to increase the state funding available for children's dental prevention and treatment services consider developing new revenue streams. One current proposal in Rhode Island recommends an increase in the state tax on cigarettes, with $8 million of the projected $20 million in revenue to be dedicated to address the current crisis in dental health, particularly among low-income children.

Form a public-private partnership to create a blueprint to expand access to dental care services for low-income children in Rhode Island.

Develop an effective public-private partnership that is committed to improving outcomes for children through increased funding for dental services, an improved dental services infrastructure, recruitment of dental service providers, and a strategic communication campaign to raise public awareness about the cost-benefit of providing dental care services to children and adolescents. Monitor progress in improving access to dental care prevention and treatment services by low-income children in Rhode Island.

Identify resources and strategies to increase access to interpreters and translation services for clients whose primary language is not English.

Work to increase the number of bilingual dental care providers. Develop effective mechanisms to improve transportation to dental service providers and locate services in neighborhoods and schools when possible.

THE FOUR LEVELS OF DENTAL TREATMENT

1. Diagnostic, Preventive, and Disease Management Services: includes health promotion, risk assessment, primary prevention, and disease suppression needed for all children.

2. Basic Restorative Care (for children with modest needs): includes dental sealants, fillings, nerve treatments, stainless steel crowns.

3. Advanced Restorative Care (for children with more complex needs).

4. Catastrophic Care (for children with severe needs).

PERFORMANCE MEASURES

Performance indicators for dental providers and plans include:

Length of time between enrollment and first dental visit.

Percentage of children receiving selected preventive services.

Percentage of children who receive treatment in a timely manner.

The following are recommendations outlined in *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need and Getting Value for State Payments*, a report by the Milbank Memorial Fund released in 1999. The report is the work of the Reforming States Group, a voluntary organization of leaders in government from more than 40 states.

GOALS OF A DENTAL INSURANCE PROGRAM FOR CHILDREN

An effective dental insurance program for children needs to address the following goals:

- Promote access to continuous primary dental care.
- Encourage dental provider participation.
- Assure accountability without undue administrative burden.
- Achieve more cost-effective use of resources.
- Target higher-needs children.
- Provide comprehensive dental care.
- Lead to improved oral health outcomes.

MEASURING SUCCESS OF A DENTAL SERVICES INSURANCE SYSTEM

Outcome indicators include:

- Reductions in the percentage of enrolled children with unmet treatment needs.
- Increases in the percentages of parents who report having a regular source of dental care for their children and who have obtained dental services.
- Percentage of children whose parents report unmet treatment needs or long delays in obtaining care.
- Rate at which parents report dissatisfaction with care.
- Percentage of children who require emergency dental care (other than injury).

Source: Milbank Memorial Fund and the Reforming States Group (1999). Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need and Getting Value for State Payments. New York: Milbank Memorial Fund.

REFERENCES

Edelstein, B.L. (May 1998). *The Cost of Caring: Emergency Oral Health Services.* Washington, DC: National Center for Education in Maternal and Child Health.

Edelstein, B.L. (1998). *Pediatric Dental Disease: A Critical Marker for Children's Overall Health*. Washington, DC: National Center for Education in Maternal and Child Health.

Children's Dental Health Project (November 1997). *Public Financing of Dental Coverage for Children: Medicaid, Medicaid Managed Care and State Programs.* Washington, DC: American Association of Dental Schools and National Center for Education in Maternal and Child Health.

Children's Dental Health Project (June 1998). *Racial and Income Disparities in Pediatric Oral Health*. Washington, DC: American Association of Dental Schools and National Center for Education in Maternal and Child Health.

Children's Dental Health Project (June 1998). *State Surveys of Oral Health Needs and Dental Care Access for Children.* Washington, DC: American Association of Dental Schools and National Center for Education in Maternal and Child Health.

Dental Care Counts: Medicaid Dental Services in Decay (2000). St. Louis, MO: Citizens for Missouri's Children.

Kenney, G.M, Ko, G. & Ormond, B.A. (April 2000). *Gaps in Prevention and Treatment: Dental Care for Low-Income Children*. Washington, DC: The Urban Institute.

Options for Delivery of Medicaid Dental Services (May 1999). Cranston, RI: Rhode Island Department of Human Services.

Oral Disease: A Crisis Among Children of Poverty (May 1998). Washington, DC: National Maternal and Child Oral Health Resource Center, Maternal and Child Health Bureau.

Oral Health in America: A Report of the Surgeon General (May 2000). Washington, DC: Department of Health and Human Services, U.S. Public Health Service; National Institutes of Health; National Institute of Dental and Craniofacial Research.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations (April 2000). Washington, DC: General Accounting Office.

Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments (1999). New York, NY: Milbank Memorial Fund, The Reforming States Group.

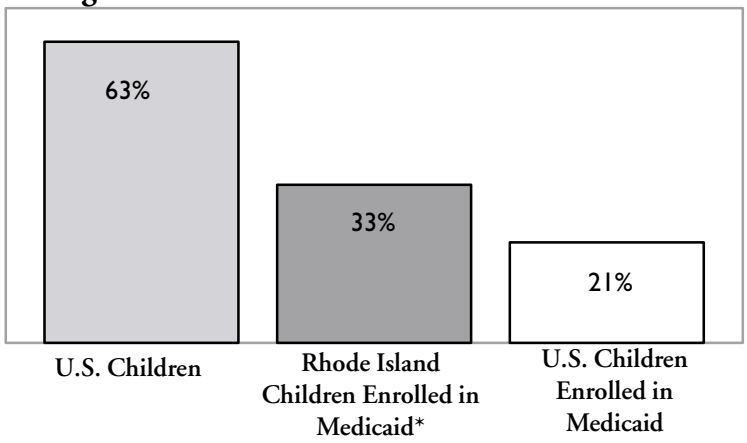
Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries (June 1999). Washington, DC: National Maternal and Child Oral Health Resource Center, Maternal and Child Health Bureau.

The Special Senate Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents (November 2001). Providence, RI: Rhode Island Special Senate Commission to Study and Make Recommendations on Ways to Maintain and Expand Access to Quality Oral Health Care for All Rhode Island Residents.

MEDICAID DENTAL SERVICES FOR CHILDREN

Under federal Medicaid regulation, children enrolled in RIte Care or Medicaid fee-for-service are entitled to comprehensive dental services, including preventive dental care, dental treatment services, translation services, and transportation.

Percentage of Children with a Dental Visit in the Previous Year



**Includes RIte Care and Medicaid fee-for-service.*

- Approximately 63% of the total U.S. child population see a dentist annually.
- Despite the entitlement to dental services under Medicaid EPSDT, one-in-five children enrolled in Medicaid in the U.S. received a single dental visit over the course of one year.
- Of all Rhode Island children under age 21 enrolled in public insurance programs, one-in-three accessed dental prevention or treatment services in FY 2000.

Source: U.S. Department of Health and Human Services, Healthy People 2000 (1990). Washington, DC: US Government Printing Office; Office of the Inspector General, Children's Dental Services Under Medicaid: Access and Utilization (1996). Washington, DC: U.S. Department of Health and Human Services; Rhode Island Department of Human Services, January 2001, includes all children enrolled in RIte Care and Medicaid fee-for-service.

ACKNOWLEDGMENTS

For assistance with this Issue Brief we thank: Linda Katz, The Poverty Institute at RI College School of Social Work; Janice Fontes, Maureen Ross, Robin Lawrence, DDS, MPH, RI Department of Health; John Andrews, Sharon Kernan, Tricia Leddy, Joan O'Bara, John Young, RI Department of Human Services; William White, Birch and Davis; Jacqueline Ascrizzi, RI Department of Elementary & Secondary Education; Christine Vallee, Daniel Kane, DMD, St. Joseph Hospital; Chris Koller, Neighborhood Health Plan of RI; Mary Callanan, DDS, Blackstone Valley Health Center; Nicholas Barone, DMD; Shirley Spater, DMD, Samuels Dental Center; Senator Elizabeth Roberts; Hillary Salmons, HELP; Karen Voci, The Rhode Island Foundation; Linda Dziobeck, Travelers Aid Society; Liz Tobin Tyler.

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation and The Annie E. Casey Foundation. Additional funding is provided by Prince Charitable Trusts, The Robert Wood Johnson Foundation, the David and Lucile Packard Foundation, the Ford Foundation, the Ewing Marion Kauffman Foundation, CVS/pharmacy and other corporate, foundation and individual sponsors.

Rhode Island* KIDS COUNT *Staff

Elizabeth Burke Bryant, Executive Director
Catherine Boisvert Walsh, Deputy Director
Wilsa Galarza, Administrative Assistant
Olinda Matos, Program Associate
Dorene Bloomer, Finance Director
Laura Beavers, Research Analyst
Veronika Kot, Policy Analyst
Sonia Rodrigues, Pawtucket Covering Kids Coordinator
Theresa Hancock, Policy Associate
Royce Conner, Policy Associate
Raymonde Charles, Program Assistant

***Rhode Island* KIDS COUNT**

One Union Station
Providence, RI 02903
401-351-9400
401-351-1758 (fax)
email: rikids@rikidscount.org
www.rikidscount.org